Rural Health Clinics and Federally Qualified Health Centers

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

August 2007

This publication supersedes all previous Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) handbooks. Published by the Montana Department of Public Health & Human Services, May 2006.

Updated August 2007.

My Medicaid Provider ID Number:

Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send e-mail inquiries to:

MTPRHelpdesk@ACS-inc.com

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about enrollment, eligibility, payments, denials, general claims questions, or to request provider manuals or fee schedules:

(800) 624-3958 In- and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Send e-mail inquiries to:

MTPRHelpdesk@ACS-inc.com

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

For PASSPORT enrollment or caseload questions:

(800) 362-8312

Send PASSPORT correspondence to:

PASSPORT To Health
P.O. Box 254
Helena, MT 59624

Medicaid Client Help Line

Clients who have Medicaid or PASSPORT questions may call the Montana Medicaid Help Line:

(800) 362-8312

Send written inquiries to:

PASSPORT To Health
P.O. Box 254
Helena, MT 59624-0254

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

PASSPORT Program Officer

Send written inquiries to:

PASSPORT Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Provider Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the G*eneral Information For Providers* manual.

Team Care Program Officer

For questions regarding the Team Care Program:

(406) 444-4540 Phone
(406) 444-1861 Fax

Team Care Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Nurse First

For questions regarding Nurse First Disease Management or the Nurse Advice Line, contact:

(406) 444-4540 Phone
(406) 444-1861 Fax

Nurse First Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In- and out-of-state
(850) 385-1705 Fax

Send e-mail inquiries to:
MTEDIHelpdesk@ACS-inc.com

Mail to:

ACS
ATTN: MT EDI
P.O. Box 4936
Helena, MT 59604

CLIA Certification

For questions regarding CLIA certification, call or write:

(406) 444-1451 Phone
(406) 444-3456 Fax

Send written inquiries to:

DPHHS
Quality Assurance Division
Certification Bureau
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

RHC and FQHC Program Officer

(406) 444-4540 Phone
(406) 444-1861 Fax

Send written inquiries to:

RHC and FQHC Program Officer
DPHHS
Hospital and Clinic Services Bureau
P.O. Box 202951
Helena, MT 59620-2951

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-5283

Chemical Dependency Bureau

For coverage information and other details regarding chemical dependency treatment, write or call:

(406) 444-4540 Phone
(406) 444-9389 Fax

Send written inquiries to:

Chemical Dependency Bureau
Addictive and Mental Disorders Division
DPHHS
P.O. Box 202905
Helena, MT 59620-2905

Lab and X-ray

Public Health Lab assistance:
(800) 821-7284 In state
(406) 444-3444 Out of state and Helena

Send written inquiries to:
DPHHS Public Health Lab
1400 Broadway
P.O. Box 6489
Helena, MT 59620

Claims for multiple x-rays of same type on same day, send to:
DPHHS
Lab & X-ray Services
Health Resources Division
P.O. Box 202951
Helena, MT 59620

Multiple Visits

Claims for multiple visits on the same day, send for review to:
DPHHS
Hospital and Clinic Section
Health Resources Division
P.O. Box 202951
Helena, MT 59620-2951

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):
(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Prior Authorization

The following are some of the Department's prior authorization contractors. Providers are expected to refer to their specific provider manual for prior authorization instructions.

Mountain-Pacific Quality Health Foundation

For questions regarding prior authorization for transplant services, private duty nursing services, medical necessity therapy reviews, and emergency department reviews:

Phone:
(800) 262-1545 X5850 In and out of state
(406) 443-4020 X5850 Helena

Fax:
(800) 497-8235 In and out of state
(406) 443-4585 Out of state and Helena

Send written inquiries to:
Mountain-Pacific Quality
Health Foundation
3404 Cooney Drive
Helena, MT 59602

First Health

For questions regarding prior authorization and continued stay review for selected mental health services.
(800) 770-3084 Phone
(800) 639-8982 Fax
(800) 247-3844 Fax

First Health Services
4300 Cox Road
Glen Allen, VA 23060

Fraud and Abuse

If you suspect fraud or abuse by an enrolled Medicaid client or provider, you may call one of the Program Compliance Bureau's fraud hotlines:

(800) 201-6308 Client Eligibility Fraud
(800) 362-8312 Medicaid Help Line (please call this number to report suspected client abuse of Medicaid)
(800) 376-1115 Provider Fraud

Key Web Sites

Web Address	Information Available
Provider Information Web Portal www.mtmedicaid.org	• Medicaid information • Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • Electronic billing information • Newsletters • Key contacts • Links to other websites and more • Montana Access to Health: Eligibility, provider summary information, claim status and payment amounts, X12 transactions, remittance advices, enrollment, and medical claims history for hospitals, physicians, and mid-level practitioners
CHIP Website www.chip.mt.gov	• Information on the Children's Health Insurance Plan (CHIP)
Centers for Disease Control and Prevention (CDC) website www.cdc.gov/nip	Immunization and other health information
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: • Provider services • EDI support • Enrollment • Manuals • Software • Companion guides • FAQs • Related links

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements
• **Eye prosthesis** • **New technology codes (Category III CPT codes)** • **Other reviews referred by Medicaid program staff**	Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602 **Phone:** (406) 457-5887 Helena (877) 443-4021 X5887 toll-free long distance **Fax:** (877) 443-2580 Toll-free local and long distance	• Documentation that supports medical necessity • Documentation regarding the client's ability to comply with any required after care • Letters of justification from referring physician • Documentation should be provided at least two weeks prior to the procedure date.

• **Circumcision**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 457-5887 Helena
	(877) 443-4021 X5887 toll-free long distance
	Fax:
	(877) 443-2580 Toll-free local and long distance
		• Circumcision requests are reviewed case-by-case basis based on medical necessity when one of the following occurs:
		  • Client has scarring of the opening of the foreskin making it non-retractable (pathological phimosis). This is unusual before five years of age. Phimosis must be treated with non-surgical methods (i.e., topical steroids) before circumcision is indicated.
		  • Documented recurrent, troublesome episodes of infection beneath the foreskin (balanoposthitis) that does not respond to other non-invasive treatments and/or sufficient hygiene
		  • Urinary obstruction
		  • Urinary tract infections

• **Maxillofacial/ cranial surgery**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 457-5887 Helena
	(877) 443-4021 X5887 toll-free long distance
	Fax:
	(877) 443-2580 Toll-free local and long distance
		• Surgical services are only covered when done to restore physical function or to correct physical problems resulting from:
		  • Motor vehicle accidents
		  • Accidental falls
		  • Sports injuries
		  • Congenital birth defects
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		• Medicaid does not cover these services for the following:
		  • Improvement of appearance or self-esteem (cosmetic)
		  • Dental implants
		  • Orthodontics

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Blepharoplasty**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 457-5887 Helena
	(877) 443-4021 X5887 toll-free long distance
	Fax:
	(877) 443-2580 Toll-free local and long distance
		• Reconstructive blepharoplasty may be covered for the following:
		  • Correct visual impairment caused by drooping of the eyelids (ptosis)
		  • Repair defects caused by trauma-ablative surgery (ectropion/entropion corneal exposure)
		  • Treat periorbital sequelae of thyroid disease and nerve palsy
		  • Relieve painful symptoms of blepharospasm (uncontrollable blinking).
		• Documentation must include the following:
		  • Surgeon must document indications for surgery
		  • When visual impairment is involved, a reliable source for visual-field charting is recommended
		  • Complete eye evaluation
		  • Pre-operative photographs
		• Medicaid does not cover cosmetic blepharoplasty

• **Botox myobloc**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 457-5887 Helena
	(877) 443-4021 X5887 toll-free long distance
	Fax:
	(877) 443-2580 Toll-free local and long distance
		• For more details on botox criteria, coverage, and limitations, visit the Provider Information website (see *Key Contacts*)
		• Botox is covered for treating the following:
		Laryngeal spasm; Blepharospasm; Hemifacial spasm of the nerve; Torticollis, unspecified; Torsion dystonia; Fragments of dystonia; Hereditary spastic paraplegia; Multiple Sclerosis; Spastic hemiplegia; Infantile cerebral palsy; Other specified infantile cerebral palsy; Achalasia and cardiospasm; Spasm of muscle; Hyperhidrosis; Strabismus and other disorders of binocular eye movements; Other demyelinating diseases of the central nervous system
		• Documentation requirements include a letter from the attending physician supporting medical necessity including:
		  • Client's condition (diagnosis)
		  • A statement that traditional methods of treatments have been tried and proven unsuccessful
		  • Proposed treatment (dosage and frequency of injections)
		  • Support the clinical evidence of the injections
		  • Specify the sites injected
		• Myobloc is reviewed on a case-by-case basis

• **Excising excessive skin and subcutaneous tissue**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 457-5887 Helena
	(877) 443-4021 X5887 toll-free long distance
	Fax:
	(877) 443-2580 Toll-free local and long distance
		• Required documentation includes the following:
		  • The referring physician and surgeon must document the justification for the resection of skin and fat redundancy following massive weight loss.
		  • The duration of symptoms of at least six months and the lack of success of other therapeutic measures
		  • Pre-operative photographs
		• This procedure is contraindicated for, but not limited to, individuals with the following conditions:
		  • Severe cardiovascular disease
		  • Severe coagulation disorders
		  • Pregnancy
		• Medicaid does not cover cosmetic surgery to reshape the normal structure of the body or to enhance a client's appearance.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Rhinoplasty septorhinoplasty**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 457-5887 Helena
	(877) 443-4021 X5887 toll-free long distance
	Fax:
	(877) 443-2580 Toll-free local and long distance
		• The following do not require PA:
		  • Septoplasty to repair deviated septum and reduce nasal obstruction
		  • Surgical repair of vestibular stenosis to repair collapsed internal valves to treat nasal airway obstruction
		• Medicaid covers rhinoplasty in the following circumstances:
		  • To repair nasal deformity caused by a cleft lip/cleft palate deformity for clients 18 years of age and younger
		  • Following a trauma (e.g. a crushing injury) which displaced nasal structures and causes nasal airway obstruction.
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		• Not covered
		  • Cosmetic rhinoplasty done alone or in combination with a septoplasty
		  • Septoplasty to treat snoring

• **Temporomandibular joint (TMJ) arthroscopy/ surgery**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 457-5887 Helena
	(877) 443-4021 X5887 toll-free long distance
	Fax:
	(877) 443-2580 Toll-free local and long distance
		• Non-surgical treatment for TMJ disorders must be utilized **first** to restore comfort and improve jaw function to an acceptable level. Non-surgical treatment may include the following in any combination depending on the case:
		  • Fabrication and insertion of an intra-oral orthotic
		  • Physical therapy treatments
		  • Adjunctive medication
		  • Stress management
		• Surgical treatment may be considered when both of the following apply:
		  • Other conservative treatments have failed (must be documented), and chronic jaw pain and dysfunction have become disabling. Conservative treatments must be utilized for six months before consideration of surgery.
		  • There are specific, severe structural problems in the jaw joint. These include problems that are caused by birth defects, certain forms of internal derangement caused by misshapen discs, or degenerative joint disease. For surgical consideration, arthrogram results must be submitted for review.
		• Not covered:
		  • Botox injections for the treatment of TMJ are considered experimental.
		  • Orthodontics to alter the bite
		  • Crown and bridge work to balance the bite
		  • Bite (occlusal) adjustments

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements
• **Partial hospitalization**	First Health Services 4300 Cox Road Glen Allen, VA 23060 **Phone:** (800) 770-3084 **Fax:** (800) 639-8982 Fax (800) 247-3844 Fax	• A certificate of need must be completed, signed, and dated no more than 30 days prior to the date of admission. • The certificate must be completed by a team of health care professionals that have competence in the diagnosis and treatment of mental illness and the patient's psychiatric condition.

• **Dermabrasion/ abrasion chemical peel**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 457-5887 Helena
	(877) 443-4021 X5887 toll-free long distance
	Fax:
	(877) 443-2580 Toll-free local and long distance
		• Services covered for the following:
		  • Treating severe, deep acne scarring not responsive to conservative treatment. All conservative treatments must have been attempted and documented for at least six months before medical necessity is determined.
		  • The removal of pre-cancerous skin growths (keratoses)
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		  • Pre-operative photographs

• **Positron emission tomography (PET) scans**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 457-5887 Helena
	(877) 443-4021 X5887 toll-free long distance
	Fax:
	(877) 443-2580 Toll-free local and long distance
		• PET scans are covered for the following clinical conditions: (For more details on each condition and required documentation, contact Mountain-Pacific Quality Health Foundation.)
		  • Solitary pulmonary nodules (SPNs) - characterization
		  • Lung cancer (non small cell) - Diagnosis, staging, restaging
		  • Esophageal cancer - Diagnosis, staging, restaging
		  • Colorectal cancer - Diagnosis, staging, restaging
		  • Lymphoma - Diagnosis, staging, restaging
		  • Melanoma - Diagnosis, staging, restaging. Not covered for evaluating regional nodes
		  • Breast cancer - As an adjunct to standard imaging modalities for staging clients with distant metastasis or restaging clients with locoregional recurrence or metastasis; as an adjunct to standard imaging modalities for monitoring tumor response to treatment for women with locally and metastatic breast cancer when a change in therapy is anticipated
		  • Head and neck cancers (excluding central nervous system and thyroid) - Diagnosis, staging, restaging
		  • Myocardial viability - Primary or initial diagnosis, or following an inconclusive SPECT prior to revascularization. SPECT may not be used following an inconclusive PET scan.
		  • Refractory seizures - Covered for pre-surgical evaluation only.
		  • Perfusion of the heart using Rubidium 82 tracer (Not DFG-PET) - Covered for noninvasive imaging of the perfusion of the heart.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Reduction mammoplasty**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 457-5887
	Helena
	(877) 443-4021
	X5887 toll-free long distance
	Fax:
	(877) 443-2580
	Toll-free local and long distance
		• Both the referring physician and the surgeon must submit documentation.
		• Back pain must have been documented and present for at least six months, and causes other than breast weight must have been excluded.
		• **Indications for female client:**
		• Contraindicated for pregnant women and lactating mothers. A client must wait six months after the cessation of breast feeding before requesting this procedure.
		• Female client 16 years or older with a body weight less than 1.2 times the ideal weight.
		• There must be severe, documented secondary effects of large breasts, unresponsive to standard medical therapy administered over at least a six month period. This must include at least two of the following conditions:
		  • Upper back, neck, shoulder pain that has been unresponsive to at least six months of documented and supervised physical therapy and strengthening exercises
		  • Paresthesia radiating into the arms. If parathesia is present, a nerve conduction study must be submitted.
		  • Chronic intertrigo (a superficial dermatitis) unresponsive to conservative measures such as absorbent material or topical antibiotic therapy. Document extent and duration of dermatological conditions requiring antimicrobial therapy.
		  • Significant shoulder grooving unresponsive to conservative management with proper use of appropriate foundation garments which spread the tension of the support and lift function evenly over the shoulder, neck and upper back.
		Documentation in the client's record must indicate and support the following:
		• History of the client's symptoms related to large, pendulous breasts.
		• The duration of the symptoms of at least six months and the lack of success of other therapeutic measures (e.g., documented weight loss programs with six months of food and calorie intake diary, medications for back/neck pain, etc.).
		• Guidelines for the anticipated weight of breast tissue removed from each breast related to the client's height (which must be documented):
		Height — **Weight of tissue per breast**
		less than 5 feet — 250 grams
		5 feet to 5 feet, 2 inches — 350 grams
		5 feet, 2 inches to 5 feet, 4 inches — 450 grams
		greater than 5 feet, 4 inches — 500 grams
		• Pre-operative photographs of the pectoral girdle showing changes related to macromastia.
		• Medication use history. Breast enlargements may be caused by various medications (e.g., sironolactone, cimetidine) or illicit drug abuse (e.g., marijuana, heroin, steroids). Although rare in women, drug effects should be considered as causes of breast enlargement prior to surgical treatment since the problem may recur after the surgery if the drugs are continued. Increased prolactin levels can cause breast enlargement (rare). Liver disease, adrenal or pituitary tumors may also cause breast enlargement and should also be considered prior to surgery.
		• **Indications for male client:**
		• If the condition persists, a client may be considered a good candidate for surgery. Clients who are alcoholic, illicit drug abusers (e.g., steroids, heroin, marijuana) or overweight are not good candidates for the reduction procedure until they attempt to correct their medical problem first.
		• Documentation required: length of time gynecomastia has been present, height, weight, and age of the client, pre-operative photographs

Other Programs

Clients who are enrolled in the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP) are not enrolled in PASSPORT, so the PASSPORT requirements in this chapter do not apply. However, prior authorization may be required for certain services. Refer to the *Mental Health* manual.

For more CHIP information, contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. Additional CHIP information is available on the Provider Information website (see *Key Contacts*).

Coordination of Benefits

When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, Workers' Compensation, employment-based coverage, individually purchased overage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* later in this chapter). Medicare coverage is processed differently than other sources of coverage.

Identifying Other Sources of Coverage

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (see *Client Eligibility and Responsibilities* in the *General Information For Providers* manual). If a client has Medicare, the Medicare ID number is provided. If a client has other coverage (excluding Medicare), it will be shown under the "TPL" section. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' Compensation insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long term care insurance

* These third party payers (and others) may **not** be listed on the client's eligibility verification.

Providers must use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Client Has Medicare

For RHCs, Medicare claims are processed and paid differently than claims involving other payers. The other sources of coverage are referred to as "third party liability" (TPL), but Medicare is not. For FQHCs, Medicare payments are handled as TPL payments.

For details on how Medicaid calculates payment for Medicare claims, see the *How Payment Is Calculated* chapter in this manual.

Medicare claims

Medicare covers RHC and FQHC covered services. These claims automatically cross over from Medicare for dually eligible clients, so providers do not need to send in their crossovers on paper. The Department's fiscal agent must have the provider's Medicare number on file to process claims and providers should include their Medicaid number on their Medicare claims.

Medicare will process the claim, submit it to Medicaid, and send the provider an Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit.

Medicare Part A and Part B crossover claims automatically cross over from Medicare.

When you receive an Explanation of Medicare Benefits from Medicare stating that your claim has been processed, please wait 45 days for that claim to cross over from Medicare to Medicaid before submitting that claim to Medicaid. This allows time for the claim to cross over and be processed through our system. If your claim is submitted to Medicaid prior to the 45-day limit, it will be returned to you as soon as it is received.

When billing Medicaid for a client with coverage from multiple sources, see the *Billing Procedures* chapter in this manual.

When Medicare pays or denies a service

- When Medicare automatic crossover claims are paid or denied, they should automatically cross over to Medicaid for processing, so the provider does not need to submit the claim to Medicaid. If Medicare denies a claim because the service was not medically necessary, Medicaid will also deny the claim.
- When Medicare crossover claims are billed on paper and are paid or denied, the provider must submit the claim to Medicaid with the Medicare EOMB (and the explanation of denial codes).

When Medicaid does not respond to crossover claims

- When Medicaid does not respond within 45 days of the provider receiving the Medicare EOMB, submit a claim and a copy of the Medicare EOMB to Medicaid for processing. When Medicaid is a secondary payor to Medicare and Medicare has paid the claim but not crossed it over to Medicaid, you must submit Medicare's payment in the "Prior Payments" form locator (54) of the UB-92 form. When Medicare has denied the service, you must attach the denial along with any explanation of denial codes to the claim.

Submitting Medicare claims to Medicaid

When submitting a paper claim to Medicaid, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must include the Medicaid provider number and Medicaid client ID number. The Medicare EOMB and explanation of denial codes are required only if the claim was denied.

When a Client Has TPL (ARM 37.85.407)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability (or TPL). In most cases, providers must bill other insurance carriers before billing Medicaid.

Providers are required to notify their clients that any funds the client receives from third party payers equal to what Medicaid paid (when the services were billed to Medicaid) must be turned over to the Department. Amounts in excess of what Medicaid paid must be returned to the provider. The following words printed on the client's statement will fulfill this requirement: "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first.

- When a Medicaid client is also covered by Indian Health Service (IHS) or the Montana Crime Victim's Compensation Fund, providers must bill Medicaid before IHS or Crime Victim's. These are not considered third party liability.
- When a client has Medicaid eligibility and Mental Health Services Plan (MHSP) eligibility for the same month, Medicaid must be billed before MHSP.
- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim form. Instead, notify the Department of the potential third party by sending the claim and notification to the Department Third Party Liability Unit:

  Third Party Liability Unit
  Department of Public Health & Human Services
  P.O. Box 202953
  Helena, MT 59620-2953

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

Requesting an exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent directly to the ACS Third Party Liability Unit (see *Key Contacts*).

- If another insurance has been billed, and 90 days have passed with no response, attach a note to the claim explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation directly to Medicaid in order to avoid missing the timely filing deadline.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
    1. The third party carrier has been billed, and 30 days or more have passed since the date of service.
    2. The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.

For details on how Medicaid calculates payment for TPL claims, see the *How Payment Is Calculated* chapter in this manual.

When the third party pays or denies a service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid in the "prior payments" form locator of the claim when submitting to Medicaid for processing.
- Allows the claim, and the allowed amount went toward client's deductible, include the insurance Reason and Remarks (formerly EOB) when billing Medicaid. With HIPAA implementation, these claims may be submitted on paper or electronically with the paper attachment mailed in separately. A paper attachment cover sheet is available on the Provider Information website (see *Key Contacts*). Until HIPAA implementation, continue to bill on paper with attachments.
- Denies the claim, include a copy of the denial (including the denial reason codes) with the claim form, and submit to Medicaid on paper.

When the third party does not respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Attach to the paper claim a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company).
- Include the date the claim was submitted to the insurance company.
- Send this information to the ACS Third Party Liability Unit (see *Key Contacts*).

Other Programs

MHSP services are not allowed for RHCs and FQHCs. Providers will find more information on Medicaid mental health services and MHSP services in the *Mental Health* manual available on the Provider Information website (see *Key Contacts*). The information in this chapter does not apply to clients enrolled in the Children's Health Insurance Plan (CHIP). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the service(s) before billing Medicaid for the service(s).

Coding

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the table of *Coding Resources* on the following page. The following suggestions may help reduce coding errors and unnecessary claim denials:

Always refer to the long descriptions in coding books.

- Use current CPT-4, HCPCS Level II, and ICD-9-CM coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use specific codes rather than unlisted codes. For example, don't use 53899 unlisted procedure of the urinary system when a more specific code is available.
- Bill for the appropriate level of service provided. Evaluation and management services have three to five levels. See your CPT manual for instructions on determining appropriate levels of service.
- CPT codes that are billed based on the amount of time spent with the client must be billed with the code that is closest to the time spent. For example, a provider spends 60 minutes with the client. The code choices are 45 to 50 minutes or 76 to 80 minutes. The provider must bill the code for 45 to 50 minutes.
- Take care to use the correct "units" measurement. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II billing manuals. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be "each 15 minutes." Always check the long text of the code description published in the CPT-4 or HCPCS Level II coding books.
- RHCs and FQHCs must use the following revenue codes as specified by the Department. Check with Provider Relations (see *Key Contacts*) to make sure they are valid for your facility. Use of these revenue codes (if invalid for your clinic) will result in nonpayment.

  B 512 Dental
  B 521 RHC/FQHC Clinic Visit
  B 522 RHC/FQHC Home Visit
  B 524 Visit by RHC/FQHC practitioner to a client in a covered Part A stay at a skilled nursing facility

B 525 Visit by RHC/FQHC practitioner to a client in a skilled nursing facility (not a covered Part A stay) or nursing facility or intermediate care facility for the mentally retarded or other residential facility

B 527 RHC/FQHC visiting nurse service(s) to a client's home when in a home health shortage area

B 528 Visit by an RHC/FQHC practitioner to other non-RHC/FQHC site (e.g., scene of accident)

Coding Resources

Please note that the Department does not endorse the products of any particular publisher.

Resource	Description	Contact
ICD-9-CM	• ICD-9-CM diagnosis and procedure codes definitions • Updated each October.	Available through various publishers and bookstores
CPT-4	• CPT-4 codes and definitions • Updated each January	American Medical Association (800) 621-8335 www.amapress.com or Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
HCPCS Level II	• HCPCS Level II codes and definitions • Updated each January and throughout the year	Available through various publishers and bookstores or from CMS www.cms.gov
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 www.amapress.com
Miscellaneous resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 www.ntis.gov/product/correct-coding.htm
UB-92 National Uniform Billing Data Element Specifications	Montana UB-92 billing instructions	MHA - An Association of Montana Health Care Providers (formerly Montana Hospital Assoc.) Box 5119 Helena, MT 59604 406-442-1911 phone 406-443-3984 fax

Number of Lines on Claim

Clinic claims are reimbursed using an all-inclusive rate of payment per visit. Only one line per claim will receive payment.

Multiple Services on Same Date (ARM 37.86.4402)

A clinic visit is defined as a face-to-face encounter between a clinic patient and a clinic health care professional for the purpose of providing clinic core or other ambulatory services or billable incident-to services. Encounters with more than one clinic health care professional, and multiple encounters with the same clinic health care professional, on the same day at a single location constitute a single visit except when one of the following exists:

- After the first encounter, the patient suffers an additional illness or injury requiring additional diagnosis or treatment, or
- The patient has a medical visit and a mental health visit, or a medical visit and a dental visit, or a mental health visit and a dental visit.

See *Key Contacts* for mailing claims for multiple visits on the same day. The second claim must be mailed directly to the RHC and FQHC program officer or it will be denied due to duplicate services.

Span Bills

Span billing is not allowed for RHCs and FQHCs. Providers may bill for only one date of service per claim. Spans greater than one date of service in form locater (FL) 6 will result in payment for one date of service. Reimbursement of other dates of service within the span is not possible until the paid claim is adjusted to reflect one date of service only.

Reporting Service Dates

- All line items must have a valid date of service in form locator (FL) 45.
- All clinic revenue codes require a valid CPT or HCPCS Level II code in form locator (FL) 44 that is appropriate for clinics.

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4 book, HCPCS Level II book, and other helpful resources (e.g., CPT Assistant, APC Answer Letter and others).
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- Medicaid accepts the same modifiers as Medicare.
- The Medicaid claims processing system recognizes only one modifier. The modifier must be added to the CPT/HCPCS code without a space or

hyphen in form locator (FL) 44. For example, 25680 (treatment of wrist fracture) when done bilaterally is reported as 2568050.

- Since the Medicaid claims processing system can read only one modifier per line, it is important to report the most important modifier first.

Service Settings

Clinic services are covered when provided in an outpatient setting including the clinic, other medical facility (including a dental office) or a patient's place of residence. A patient's place of residence may be a nursing facility or other institution used as the patient's home. Clinic services are covered off-site as long as the service is normally furnished within the scope of the clinic's professional services. Services provided off-site are part of the clinic benefit if the provider has an agreement with the clinic that Medicaid payment will be made to the clinic for those services. If the clinic doesn't compensate the provider for services provided off-site, the clinic may not bill Medicaid for those services.

FQHCs must not bill in the hospital setting. RHCs may bill in the hospital setting but not for inpatient surgeries and deliveries.

FQHC providers that perform services in a hospital setting must bill the service on a CMS-1500 using their own provider number. RHC providers who perform inpatient surgeries or deliveries must unbundle the service and bill for the surgery (using modifier 54) or delivery only (procedure codes 59409 or 59514) on a CMS-1500 using their own provider number.

Pre- and post-visits at the clinic are billed by the clinic on a UB-92 as a core service.

Submitting a Claim

Paper claims

Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Electronic claims

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ACS field software WINASAP 2003. ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers.

Client Has Medicaid and Medicare Coverage

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Better Provider 33 Best Road Fitness, MT 59003		45604	791

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	02/01/06	02/01/06					

12 PATIENT NAME	13 PATIENT ADDRESS
Leaves, Autumn T.	45 Maple Lane Trees, MT 59400

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
05/28/67	F		02/01/06	10		1		01									

	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37	
a												A	a
b												B	b
												C	

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT	
a	A1	11.00					a
b							b
c							c
d							d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	521	Office/Outpatient Visit, est.	99212	02/01/06	1	55.00			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23						55.00			23

The payers in FL 50 must correspond with the payment(s) in FL 39.

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	
A	Medicare	006341			75.58			A
B	Medicaid	0413214						B
C								C
57		DUE FROM PATIENT ▶						

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.	
A	Leaves, Autumn T.		134637825			A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	
A					A
B					B
C					C

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68	69	70	71	72	73	74	75	76 ADM. DIAG. CD.	77 E-CODE	78
692.9									692.9		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	C		D		E	

82 ATTENDING PHYS. ID		
0006240	Dr. Patients	
83 OTHER PHYS. ID	A	a
		b
OTHER PHYS. ID	B	a
		b

a	84 REMARKS
b	
c	
d	

85 PROVIDER REPRESENTATIVE	86 DATE
X Nina Numbers	02/15/06

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Client Has Medicaid and Third Party Liability Coverage

FL	Form Locator Title	Instructions
1-2	Unlabeled fields	Provider name, complete mailing address, and phone number
3	Patient control number	The client's unique alphanumeric number assigned by the provider
4	Type of bill	Enter the code indicating the type of bill (711 for RHCs, 791 for FQHCs)
6	Statement covers period	The beginning and ending service date of the period included on this bill
11*	PASSPORT To Health	Enter PASSPORT authorization number or indicator code (see *PASSPORT and Cost Sharing Indicators* earlier in this chapter)
12	Patient name	Enter the Medicaid client's last name, first name and middle initial
13	Patient address	The client's mailing address including street name/P.O. box, city, state, and zip code
14	Patient birth date	The client's month, day, and year of birth
15	Patient sex	Enter M (male), F (female), or U (unknown)
17-20	Admission	The admission date, hour, type, and source (see to the UB-92 Reference Manual for specific codes)
22	Patient status	A code indicating client status as of the ending service date of the period covered on this bill (see the UB-92 Reference Manual for specific codes)
39-41*	Value codes and amounts	Enter value codes A1, A2, A3, B1, B2, B3, etc. followed by the deductible and coinsurance amounts. These entries must correspond with the entries in form locator 50 (A, B). See the *Billing Procedures* chapter, *Billing with multiple payers* section in this manual.
42	Revenue code	A code which identifies a specific accommodation, ancillary service or billing calculation (see the UB-92 Reference Manual for specific codes)
43	Description	Revenue code description (may abbreviate).
44	HCPCS Rates	Enter the CPT/HCPCS code for the service
45	Service date	The date the indicated service was provided
46	Service units	A quantitative measure of services rendered by revenue category to or for the client to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc. Must be appropriate for the procedure code, if listed.
47	Total charges	Total charges (covered and non-covered) for this line.
50	Payer	The entries in this form locator correspond with the entries in form locators 39-41. See the *Billing Procedures* chapter, *Billing with multiple payers* section in this manual.
51	Provider number	Enter the provider's TPL and Medicaid ID numbers
54	Prior payments	The amount the provider has received toward payment of this bill
58	Insured's name	Name of the individual in whose name the insurance is carried
60	Cert - SSN - HIC - ID #	Client's Medicaid ID number
63*	Treatment auth. code	Enter the prior authorization code for the service. This form locator is required for all out-of-state billers an some in-state services.
67-75	Principal diagnosis code	Use the ICD-9-CM code for the principal diagnosis. Enter additional diagnoses codes in form locators 68-75
76	Admitting diagnosis code	The ICD-9-CM code for the client's diagnosis or reason for visit
78	Unlabeled field	Enter applicable cost sharing indicator code (see *PASSPORT and Cost Sharing Indicators* earlier in this chapter)
82	Attending physician ID	For non-emergency outpatient services, enter the referring physician's Medicaid ID number. For emergency services, enter the emergency department physician's Medicaid ID number
85-86	Provider representative signature and date	An authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications of the back of this bill

* Required if applicable